State of Virginia

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CI AND PLAN OF CORRECTION IDENTIFICATION NUMBE			(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			-				
		VA0270		B. WING		09/29/2016	
NAME OF PI	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
WESTDOE	RT REHABILITATION ANI	NI IDSING CENTEI	7300 FORE	ST AVE			
WESTFOI	NETIABLETIATION AND	D NORSING CENTER	RICHMONE	), VA 23226			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FU .SC IDENTIFYING INFORMATIO		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPL	ETE
F 000	Initial Comments			F 000			
		acted 9/27/16 through are required for compliant the Virginia Rules and	ance				
	The census in this 225 licensed/certified bed facility was 178 at the time of the survey. The survey sample consisted of 24 current resident reviews (Residents #1 through #24)) and 35 closed record reviews (Residents #25 through #35).		e ent				
F 001	Non Compliance			F 001		10/21/	16
	The facility was out of following state licensu						
	This RULE: is not met as evidenced by: 12 VAC 5 - 371 - 360 Clinical Records cross references to F 514 Resident assessment and care planning F278 cross reference 12VAC5-371-250E Nursing Services				Cross Reference F514  1. Corrective Action The physician and responsible party v notified of residents random refusals of Senexon S Tab 8.6 - 50 MG		
	F282 cross reference F325 cross reference				The Hospice provider for Resident #6 contacted and instructed to place all Hospice notes on the chart	was	
	Maintenance and Hou F465 cross reference				2.Other Potential Residents     An audit of the MARS (Medication		
	12VAC5-371-250. Re planning cross reference to F2	sident assessment and 79	care		Administration Records) for other residents on unit 3 was completed and other residents were affected.	i no	
	12VAC5-371-370. Ma housekeeping Cross reference to F-				An audit was completed for all hospice residents to validate that the hospice notes were present. No other resident		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

**Electronically Signed** 

10/21/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/G IDENTIFICATION NUMB		o	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		VA0270	B. WING _		09	/29/2016
	ROVIDER OR SUPPLIER	ID NURSING CENTEL	STREET ADDRESS, CITY 7300 FOREST AVE RICHMOND, VA 2322			
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			PROVIDER'S PLAN OF (  (EACH CORRECTIVE ACTIVE)  CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
F 001	Continued From pag	e 1	F 001	were affected.  3. System Changes Licensed Nurses were re-ecappropriate documentation of MARS (Medication Administ Records) for a medication thand the need for physician regarding the refusal.  A 100% audit of all MARS (Medication Records) will weekly x 3months to validate with documentation and not Unit Managers were re-eduction all documentation to be contact.  A 100% audit will be complete months of all residents on Heservices to validate present documentation.  Any areas of non-compliance immediately corrected and seresponsible will be counseled.  4. Monitoring Results of the audits will be the QAPI Committee for furth and recommendations.  Cross Reference F278 Corrective Action 1. The MDS (Minimum Data Resident # 4 has been correct the coding of dialysis.  2. Other Potential Residents An audit of the MDS (Minimum)	on back of tration nat is refused notification  Medication be completed to compliance ification.  cated on need on residents  eted weekly x 3 dospice to of hospice to forwarded to ther review  Set) for ected to reflect	

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		VA0270		B. WING		09/2	9/2016
	ROVIDER OR SUPPLIER	D NURSING CENTEI	STREET ADDRI 7300 FORES RICHMOND,		TE, ZIP CODE		
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F 001	Continued From page	• 2		F 001	Set)for all other residents who were receiving dialysis was completed and other residents were affected.  3. System Changes The MDS/Care plan Nurses were re-educated on accurate coding of MI (Minimum Data Set)Assessments for residents receiving dialysis.  A 100% audit of the MDS (Minimum Data Set)for all dialysis residents will be completed weekly x 3 months to valid accurate coding of dialysis. Any areas non-compliance will be immediately corrected and staff responsible will be counseled.  4. Monitoring Results of the audits will be forwarded the QAPI Committee for further review and recommendations.  Cross Reference F282 1. Corrective Action The CNA Responsible for providing pudding thickened liquids to Resident #16 was immediately counseled and re-educated regarding providing the correct consistency of liquids based or physicians orders.  2. Other Potential Residents A review of all residents with physician orders for thickened liquids was conducted on 9/28/16 for the lunch timeal and no other residents were affected.  3. System Changes Nursing staff were re-educated regard.	DS Data ate of to v	

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	ROVIDER OR SUPPLIER	O NURSING CENTEI	REET ADDRESS, CITY, 1800 FOREST AVE CHMOND, VA 23220		
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F 001	Continued From page	• 3	F 001	providing the correct consistency of based on physicians orders.  An observation of all residents with physicians orders for thickened liquide conducted weekly x 3 months to validate that the resident is receiving correct consistency of thickened liquident and y areas of non-compliance will be immediately corrected and staff responsible will be counseled.  4. Monitoring  Results of the audits will be forwarded the QAPI Committee for further review and recommendations.  Cross Reference F325  1. Corrective Action  The CNA Responsible for providing pudding thickened liquids to Resident #16 was immediately counseled and re-educated regarding providing the correct consistency of liquids based physicians orders.  2. Other Potential Residents  A review of all residents with physicians orders for thickened liquids was conducted on 9/28/16 for the lunch the meal and no other residents were affected.  3. System Changes  Nursing staff were re-educated regar providing the correct consistency of based on physicians orders.  An observation of all residents with physicians orders for thickened liquid be conducted weekly x 3 months to validate that the resident is receiving	ds will g the gids.  ed to ew  hts f on ans ime rding liquids ds will

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F 001	Continued From page	.4	F 001	correct consistency of thickened liquid Any areas of non-compliance will be immediately corrected and staff responsible will be counseled.  4. Monitoring Results of the audits will be forwarded the QAPI Committee for further review and recommendations.  Cross Reference F465 1.Corrective Action The Clorox Disinfectant spray was removed from the shower room by the manager.  2.Other Potential Residents All other shower rooms were checked 9/29/16 and cabinets were locked.  3.System Changes Nursing Staff were re-educated on masure that the cabinets in the shower roare locked when not in use. An observation of all shower rooms we conducted weekly x 3 months to valid that the cabinets are being kept locked. Any areas of non compliance will be immediately corrected and staff responsible will be counseled.  4.Monitoring Results of observations will be forward to the QAPI Committee for further reveand recommendations.  Cross Reference F279 1. Corrective Action The care plan for Resident #1 was updated to reflect a care plan for the	d to v e unit d on aking ooms vill be late dd.

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F 001	Continued From pag	e 5	F 001	triggered care area of dental care.  2.Other Potential Residents An audit of the Care Plan for reside triggered for dental care on the CAA Area Assessment)was completed a other residents were affected.  3.System Changes MDS/Care plan nurses were re-edu on process to ensure that the care presidents that trigger in the CAA (Ca Area Assessment) for dental care he care plan that addresses that need. A 100% audit of all residents that trithe CAA (Care Area Assessment) for dental care will be completed weekl months to validate presence of the plan for dental care. Any areas of non-compliance will be immediately corrected and staff responsible will counseled.  4. Monitoring Results of the audits will be forward the QAPI Committee for further reviand recommendations.  Cross Reference F252 1.Corrective Action The wheelchair cushion for resident was replaced on 9/29/16  2.Other Potential Residents Wheelchair cushions were checked other residents that have them in pland no other residents were affected.  3.System Changes Staff were re-educated to observe for the care of the care plant o	cated plan for are as a gger in or y x 3 care be we	

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F 001	Continued From page	e 6		F 001	wheelchair cushions that need to be repaired or replaced during their daily interactions with residents. Rounds of all units will be completed weekly x 3 months to validate that residents have appropriate wheelcha cushion's that are not in need of repareplacement Any areas of non-compl will be immediately corrected and staresponsible will be counseled.  4. Monitoring Results of the rounds will be forwarde the QAPI Committee for further review and recommendations.	ir ir or iance ff		